2010 OPTION 2

HEALTH INSURANCE ELECTION

FOR STATE OF MONTANA LEGISLATORS

Complete this form to designate your election to waive coverage (health, dental and life) under the State of Montana Employee Benefits Plan and apply the State Share contribution to other health insurance coverage. ***The Premium Statement on the back of this page must also be completed.***

_____

Employer Providing Alternate Coverage

_____

Address

_____

City State Zip

_____

Phone

_____

Insurance Carrier

_____

Address

_____

City State Zip

_____

Policy Number

I understand that the State contribution will be paid on the last day of each month. I further understand that it remains my responsibility to pay any portion of the alternate coverage premium which is over the current State contribution. I understand that my COBRA rights are voided if I choose this option.

_____ _____

Signature Date

Revised 11/09

PREMIUM STATEMENT

_____ _____

Legislator's Name Social Security Number

_____

Address

_____

City State Zip

_____

Phone Number

ALTERNATE COVERAGE INFORMATION

Total Monthly Premium: $_____

Employer Contribution: $_____

Remaining Balance: = $_____ **

** The State of Montana will pay this amount providing it does not exceed the monthly State Contribution of $679.00 for 2010.

Make Check Payable to: _____

Mail Check to: _____

_____

_____

Instructions: Complete all requested information regarding the Legislator and the Alternate Insurance. **This information must be accompanied with documentation from your Insurance provider showing your out-of-pocket premium costs**. You are required to notify the Health Care & Benefits Division of any changes in your alternate coverage. We request this notification within 60 days of the effective date of the change. We are unable to adjust for premium change amounts beyond 60 days. Payments for Alternate Coverage are processed on the last working day of each month.